UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

UNITED STATES OF AMERICA, ex rel. Mark Swift, Plaintiff, v. DELIVERCARERX, INC., Defendant.	))))))))))	Civil Action No. 1:14-cv-07976

FIRST AMENDED COMPLAINT

OVERVIEW OF COMPLAINT

1. This is a civil action brought by relator Mark Swift ("Relator") on his own behalf and on behalf of the United States of America ("United States") against DELIVERCARERX, INC. ("Defendant" or "DeliverCareRx") under the *qui tam* provisions of the Civil False Claims Act, 31 U.S.C. § 3729, *et seq.* (the "False Claims Act" or "FCA"), to recover damages, civil penalties, and other relief owed to the United States and Relator.

2. In connection with the receipt of payment from the United States Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), Defendant committed fraud against the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§1395-1395ccc and 42 C.F.R. Parts 400-1004, by (a) knowingly presenting, and causing to be presented to an officer and employee of the United States Government false and fraudulent claims for payment and approval; and (b) knowingly making, using, and causing to be made and used, false records and statements to get false and fraudulent claims paid and approved by the Government, in violation of 31 U.S.C. §§ 3729(a)(1) and (2).

3. In brief, Defendant, DeliverCareRx, an approved supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") and Medicare Part B provider has and continues to directly solicit thousands of Medicare and Medicaid patients via telephone in violation of Federal law. As a result of these thousands of illegal solicitations, DeliverCareRx made tens of thousands of false claims for payment.

II. PARTIES

4. Relator, Mark Swift, is a resident of the State of Illinois. Mark Swift was employed by Defendant as a consultant from October 24, 2012, until May 21, 2014.

5. Defendant, DeliverCareRx, Inc. ("DeliverCareRx"), is a corporation organized and existing under the laws of the State of Delaware with its principal place of business located at 2100 Rexford Road, Suite 216, Charlotte, North Carolina 28211.

6. 44% of DeliverCareRx patients are Medicare beneficiaries.

7. 56% of DeliverCareRx patients are Medicaid beneficiaries.

III. JURISDICTION AND VENUE

8. This Court has subject matter jurisdiction over the claims alleged in this Complaint under 28 U.S.C. §§ 1331 (Federal question), 1345 (United States as plaintiff) and 31 U.S.C. § 3732(a) (False Claims Act).

9. This Court has personal jurisdiction over the Defendant pursuant to 31 U.S.C. § 3732(a) because the Defendant transacts business in the Northern District of Illinois and an act proscribed by 31 U.S.C. § 3729 occurred within this District. Defendant submitted false claims on behalf of Medicare and Medicaid beneficiaries residing in Chicago, Illinois.

10. Upon information and belief, there are no pending actions that would be deemed to be related to this action, and further, this Complaint is not based on the facts underlying any

such pending action, within the meaning of the False Claims Act's first to file rule, 31 U.S.C. § 3730(b)(5).

11. This action is not precluded by any provisions of the False Claims Act's jurisdiction bar, 31 U.S.C. § 3730(e) *et seq.*

a. Upon information and belief, this Complaint is not based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the United States is already a party. 31 U.S.C. §3730(e)(3).

b. Upon further information and belief, there has been no "public disclosure" of the matters alleged herein and this action is not "based upon" any such disclosure within the meaning of 31 U.S.C. §3730(e)(4)(A).

c. Notwithstanding the foregoing, Relator is an "original source" of this information as defined by 31 U.S.C. §3730(e)(4)(B) of the False Claims Act, and as such, they are expressly excepted from its public disclosure bar.

12. Venue is proper in the Northern District of Illinois under 28 U.S.C. §§ 1391(b)(2) and 31 U.S.C. § 3732(a), because DeliverCareRx transacts business within this District.

IV. THE FEDERAL FALSE CLAIMS ACT

13. The False Claims Act (FCA) was originally enacted in 1863, and was substantially amended in 1986 by the False Claims Amendments Act, Pub.L. 99-562, 100 Stat. 3153. Congress enacted the 1986 amendments to enhance and modernize the Government's tools for recovering losses sustained by frauds against it after finding that federal program fraud was pervasive. The amendments were intended to create incentives for individuals with knowledge of Government frauds to disclose the information without fear of reprisals or Government inaction,

and to encourage the private bar to commit resources to prosecuting fraud on the Government's behalf.

14. The Act provides that any person who presents, or causes to be presented, false or fraudulent claims for payment or approval to the United States Government, or knowingly makes, uses, or causes to be made or used false records and statements to induce the Government to pay or approve false and fraudulent claims, is liable for a civil penalty ranging from $5,500 up to $11,000 for each such claim, plus three times the amount of the damages sustained by the federal Government.

15. The Act allows any person having information about false or fraudulent claims to bring an action for himself and the Government, and to share in any recovery. Based on these provisions, *qui tam* plaintiff and Relator seeks through this action to recover all available damages, civil penalties, and other relief for state and federal violations alleged herein.

16. The FCA establishes liability to the United States for an individual who, or entity that, "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," § 3729(a)(i)(A); or "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," § 3729(a)(1)(B). "Knowingly" is defined to include actual knowledge, reckless disregard and deliberate indifference.

18. Although the precise amount of the loss from Defendant's misconduct alleged in this action cannot presently be determined, it is estimated that the damages and civil penalties that may be assessed against the Defendant under the facts alleged in this Complaint amounts to millions of dollars.

19. Medicare and Medicaid accounts for nearly 100% of Defendant's payor sources and Defendant generates millions in revenue each year.

V. MEDICARE

20. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program. Medicare is a federally-funded health insurance program primarily benefitting the elderly. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. See 42 U.S.C. § 426 et seq.

21. The Medicare program is administered through the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS").

Medicare Part B

22. Title XVIII of the Social Security Act prescribes coverage requirements under Part B of the Medicare program. Medicare Part B covers services and items including durable medical equipment ("DME"). DME is "equipment furnished by a supplier . . . that -- (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) generally is not useful to an individual in the absence of an illness or injury; and (4) is appropriate for use in the home." 42 C.F.R. § 414.202.

23. Medicare Part B covers blood sugar self-testing equipment, including blood sugar monitors, blood sugar testing strips, lancet devices, lancets and glucose control solutions if the patient meets these requirements: 1) the patient is under a physician's care for diabetes; 2) the accessories and supplies have been ordered by the patient's treating physician; 3) the patient (or patient's caregiver) has been trained to use the required equipment in an appropriate manner; and 4) the equipment is designed for home rather than clinical use.

24. To become a Medicare DME supplier, an entity such as DeliverCareRx must complete a CMS Form 855S (Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies). In this form, suppliers must certify the following:

"I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the supplier's compliance with all applicable conditions of participation in Medicare."

DeliverCareRx Medicare Enrollment Application attached hereto as Exhibit "A" and incorporated herein.

25. DeliverCareRx must meet and must certify in its application for billing privileges that it "[o]perates its business and furnishes Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements." 42 CFR § 424.57(c)(1).

26. DeliverCareRx supplied patients with Medicare Part B supplies and services.

27. As detailed below, as of September 17, 2013, DeliverCareRx was an approved supplier of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS).

28. DMEPOS suppliers such as DeliverCareRx are prohibited from cold calling Medicare beneficiaries pursuant to 42 CFR § 424(C)(11).

Medicare Part D

20. Part D of the Medicare Program was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, to provide prescription drug benefits for Medicare beneficiaries. Medicare Part D became effective January 1, 2006. All persons enrolled in Medicare Part A and/or Medicare Part B are eligible to enroll in a prescription drug plan under Part D. HHS, through its component agency, CMS, contracts with private companies (or "Part D sponsors") to administer prescription drug plans. Such companies are regulated and subsidized by CMS pursuant to one-year, annually renewable contracts. Part D

sponsors enter into subcontracts with many pharmacies such as DeliverCareRx to provide drugs to the Medicare Part D beneficiaries enrolled in their plans.

21. Generally, after a physician writes a prescription for a patient who is a Medicare beneficiary, that patient can take the prescription to a pharmacy to be filled. When the pharmacy dispenses drugs to the Medicare beneficiary, the pharmacy submits a claim electronically to the beneficiary's Part D sponsor (sometimes through the sponsor's pharmacy benefit manager, or "PBM"). The pharmacy receives reimbursement from the sponsor (or PBM) for the portion of the drug cost not paid by the beneficiary. The Part D sponsor is then required to submit to CMS an electronic notification of the drug dispensing event, called the Prescription Drug Event ("PDE"), which contains data regarding the prescription claim, including the service provider of the drug, the prescriber of the drug, the quantity dispensed, the amount it has paid to the pharmacy, and whether the drug is covered under the Medicare Part D benefit.

22. Payments to a Part D Plan sponsor are conditioned on the provision of information to CMS that is necessary for CMS to administer the Part D program and make payments to the Part D Plan sponsor for qualified drug coverage. 42 C.F.R. § 423.322. CMS's instructions for the submission of Part D prescription PDE claims data state that "information ... necessary to carry out this subpart" includes the data elements of a PDE. PDE records are an integral part of the process that enables CMS to administer the Part D benefit. Each PDE that is submitted to CMS is a summary record that documents the formal adjudication of a dispensing event based upon claims received from pharmacies and serves as the request for payment for each individual prescription submitted to Medicare under the Part D program.

23. In order to receive Part D funds from CMS, Part D Plan contractors, such as DeliverCareRx, are required to comply with all applicable federal laws, regulations, and CMS instructions.

24. By statute, all contracts between a Part D Plan contractors and the Department of Health and Human Services must include a provision whereby the Plan sponsor agrees to comply with the applicable requirements and standards of the Part D program as well as the terms and conditions of payment governing the Part D program. 42 U.S.C. § 1395w-112.

25. Medicare Part D Plan sponsors must also certify in their contracts with CMS that they agree to comply with all federal laws and regulations designed to prevent fraud, waste, and abuse, including the False Claims Act 42 C.F.R.§ 423.505(h)(l).

26. As detailed below, DeliverCareRx submitted and/or caused claims to be submitted to Medicare Part D for services to Medicare recipients.

VI. MEDICAID

27. In 1965, Congress enacted Title XIX of the Social Security Act to expand the nation's medical assistance program for the needy and the medically needy aged, blind, disabled, and families with dependent children. 42 U.S.C. §§ 1396-1396v. This became known as the "Medicaid Program." The Medicaid Program is funded by both Federal and State monies, collectively referred to as "Medicaid Funds," with the federal contribution computed separately for each state. 42 U.S.C. §§ 1396b and 1396d(b).

28. Each State is permitted, within certain parameters, to design its own medical assistance plan, subject to approval by HHS. Among other forms of medical assistance, the States are permitted to provide medical assistance from the Medicaid Funds to eligible persons for outpatient prescription drugs. 42 U.S.C. § 1396a(10) (A); 1396d(a) (12).

29. HHS is an agency of the United States and is responsible for the administration, supervision and funding of the federal Medicaid Program. CMS is the division of HHS that is directly responsible for administering the federal Medicaid Program. Prior to 2001, CMS was known as the Health Care Finance Administration, or "HCFA."

30. The Medicaid program was also created in 1965 as part of the Social Security Act, which authorized federal grants to states for medical assistance to low-income, blind, or disabled persons, or to members of families with dependent children or qualified pregnant women or children. The Medicaid program is jointly financed by the federal and state governments. CMS administers Medicaid on the federal level. Within broad federal rules, each state determines eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. The states directly pay providers, with the states obtaining the federal share of the payment from accounts that draw on the United States Treasury. 42 C.F.R. §§ 430.0-430.30 (1994).

31. The federal share of Medicaid expenditures varies by state and can fluctuate annually.

32. In Illinois, providers participating in the Medicaid program submit claims for services rendered to recipients to the Illinois Department of Healthcare and Family Services for payment.

33. As detailed below, DeliverCareRx submitted and/or caused claims to be submitted to Medicaid for services to Medicaid recipients.

VII. FALSE CLAIMS ACT ALLEGATIONS

34. In direct violation of federal law, DeliverCareRx directly solicits Medicare and Medicaid beneficiaries via telephone.

35. A claim that includes items or services resulting from a violation of federal law constitutes a false or fraudulent claim for purposes of False Claims Act. 42 U.S.C. § 1320a-7b(g)

36. DeliverCareRx agreed to the following:

> "...abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. **I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the supplier's compliance with all applicable conditions of participation in Medicare.**" (emphasis added)

37. DeliverCareRx, like nearly every pharmacy, including Walgreens and CVS, is an approved DMEPOS supplier.

38. DeliverCareRx, through its President Steven Purdy, submitted an application to be a DMEPOS supplier on or about April 17, 2013. Application attached hereto as Exhibit "A" and incorporated herein.

39. On September 13, 2013, Palmetto GBA, a Medicare administrative contractor, approved DeliverCareRx's DMEPOS supplier application. The approval letter provides in pertinent part: "All suppliers are required to maintain compliance with Medicare DMEPOS supplier standards. To promote a higher level of ethical and lawful conduct within the DMEPOS program, the Office of Inspector General has developed a Program Compliance Guidance." Letter from Palmetto GBA attached hereto as Exhibit "B" and incorporated herein.

40. On April 26, 2013, DeliverCareRx President Steven Purdy, executed a Medicare Part B participating provider agreement, wherein he agreed to receive Medicare Part B funding. This agreement is limited to those who bill for "physicians professional services, services and supplies incident to a physician's professional services, outpatient physical therapy services,

diagnostic tests, or radiology services" Medicare Part B agreement attached hereto as Exhibit "C" and incorporated herein.

41. Federal law specifically prohibits DeliverCareRx from making "any false statement or representation of a material fact in any application for any. . . payment under a Federal health care program." See 42 U.S.C. §1320-a-7b(a)(l).

42. Federal law specifically prohibits DeliverCareRx from direct solicitation of Medicare beneficiaries by telephone for the sale of pharmaceuticals. 42 CFR 423.2268 (d).

43. Federal law prohibits DeliverCareRx from engaging in any other marketing activity prohibited by CMS in its marketing guidance 42 CFR 423.2268 (o).

44. Federal law prohibits the direct solicitation of a Medicare beneficiary when supplying a Medicare covered item (including Part D prescriptions), unless: (i) The individual has given written permission to the supplier or the ordering physician or non-physician practitioner to contact them concerning the furnishing of a Medicare-covered item that is to be rented or purchased; (ii) The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item; (iii) If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact. 424.57 CFR (b)(11).

45. Direct solicitation is defined as direct contact, which includes, but is not limited to, telephone, computer, e-mail, instant messaging or in-person contact, by a DMEPOS supplier or its agents to a Medicare beneficiary without his or her consent for the purpose of marketing the DMEPOS supplier's health care products or services or both. 42 C.F.R. § 424.57(a).

46. DeliverCareRx directly solicited thousands of Medicare and Medicaid patients via telephone.

47. As of the date of this complaint being filed, DeliverCareRx continues to directly solicit Medicare and Medicaid patients via telephone.

48. DeliverCareRx purchased lists of names and phone number containing exclusively Medicare and Medicaid patients throughout the United States.

49. The call lists were then utilized in DeliverCareRx's offshore call center to solicit beneficiaries in the United States.

50. Mark Swift was removed from his role as manager of the call center so that DeliverCareRx President, Steven Purdy, could directly oversee the use and implementation of purchased lists.

51. DeliverCareRx purchased the lists because they were all Medicare and Medicaid patients.

52. The call list titles, such as "Medicare" and "Illinois Medicaid", make clear that the lists were illegal.

53. DeliverCareRx cannot cold call thousands of Medicare patients for Part D supplies then use that initial contact to make and end-run around the rules prohibiting cold calling to solicit DMEPOS supplies when they commence large scale sale of DMEPOS supplies.

54. DeliverCareRx submitted and/or caused tens of thousands of claims to be submitted to Medicaid, Medicare Part B, and Medicare Part D on behalf of thousands of patients it illegally solicited for medical supplies and prescription drugs.

VIII. CLAIMS

COUNT I
False Claims Act 31 U.S.C. § 3729(a)(1) and (a)(2)

55. Relator realleges and incorporates by reference the allegations contained in Paragraphs 1 through 54 of this Complaint.

56. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729, et seq., as amended.

57. By virtue of the acts described above, Defendant knowingly presented or caused to be presented to the United States Government thousands of false or fraudulent claims for the payment.

58. By virtue of the acts described above, Defendant knowingly made, used or caused to be made or used false records or statements to cause a false or fraudulent claim to be paid or approved by the United States Government.

59. The United States, unaware of the falsity of the records, statements or claims made by the defendants, paid the Defendant for claims that would otherwise not have been allowed.

60. By reason of these payments, the United States has been damaged, and continues to be damaged, in a substantial amount.

WHEREFORE, Relator, Mark Swift, requests that judgment be entered against Defendant, ordering that:

a. Defendant pays not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. § 3729 plus three times the amount of damages the United States has sustained because of Defendant's actions;

b. Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. §3730(d);

c. Relator be awarded all costs of this action, including attorneys' fees and costs pursuant to 31 U.S.C. § 3730(d);

d. The United States and Relator recover such other relief as the Court deems just and proper.

PLAINTIFFS DEMAND A TRIAL BY JURY.

Date: June 19, 2015

Respectfully submitted,

UNITED STATES OF AMERICA
ex rel. MARK SWIFT,
Plaintiff

By:
One of His Attorneys

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Dated: June 19, 2015

EXHIBIT A

MEDICARE ENROLLMENT APPLICATION

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

CMS-855S

SEE PAGE 1 FOR A SUMMARY OF THE DMEPOS SUPPLIER STANDARDS. TO ENROLL IN THE MEDICARE PROGRAM AND BE ELIGIBLE TO SUBMIT CLAIMS AND RECEIVE PAYMENTS, EVERY DMEPOS SUPPLIER APPLICANT MUST MEET AND MAINTAIN THESE ENROLLMENT STANDARDS.

SEE PAGE 2 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.

SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

TO VIEW YOUR CURRENT MEDICARE ENROLLMENT RECORD GO TO:
HTTPS://PECOS.CMS.HHS.GOV

Form Approved
OMB No. 0938-1056

DMEPOS SUPPLIER STANDARDS FOR MEDICARE ENROLLMENT

Below is an abbreviated summary of the standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, including the surety bond provisions, are listed in 42 CFR § 424.57(c) and (d) and can be found at http://www.cms.gov/MedicareProviderSupEnroll/10_DMEPOSSupplierStandards.asp#TopOfPage.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual whose signature is binding sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. A supplier cannot contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57(c)(11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its' Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. A supplier must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. A supplier must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. A supplier must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57(d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act), physical and occupational therapists or DMEPOS suppliers working with custom made orthotics and prosthetics.

WHO SHOULD COMPLETE AND SUBMIT THIS APPLICATION

The following types of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers must complete this application to enroll in the Medicare program and receive a Medicare Billing number:

- Ambulatory Surgical Center
- Department Store
- Grocery Store
- Home Health Agency
- Hospital
- Indian Health Service or Tribal Facility
- Intermediate Care Nursing Facility
- Medical Supply Company
- Nursing Facility (other)
- Ocularist
- Occupational Therapist
- Optician
- Orthotics Personnel
- Oxygen and/or Oxygen Related Equipment Supplier
- Pedorthic Personnel
- Pharmacy
- Physical Therapist
- Physician, including Dentist and Optometrist
- Prosthetics Personnel
- Prosthetic/Orthotic Personnel
- Rehabilitation Agency
- Skilled Nursing Facility
- Sleep Laboratory/Medicine
- Sports Medicine

If your DMEPOS supplier type is not listed, contact the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) before you submit this application.

Complete this application if you plan to bill or already bill Medicare for DMEPOS and you are:

- Enrolling in Medicare for the first time as a DMEPOS supplier.
- Currently enrolled in Medicare as a DMEPOS supplier and need to report changes to your current business, (e.g., you are adding, removing, or changing existing information under this Medicare supplier billing number). Changes must be reported within 30 days of the change.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using the same tax identification number already enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and need to enroll a new business location using a tax identification number not currently enrolled with the NSC MAC.
- Currently enrolled in Medicare as a DMEPOS supplier and received notice to revalidate your enrollment.
- Reactivating your Medicare DMEPOS supplier billing number.
- Voluntarily terminating your Medicare DMEPOS supplier billing number.

DMEPOS suppliers can apply for enrollment in the Medicare program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The paper CMS-855S enrollment application. Be sure you are using the most current version.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS and to get the current version of the CMS-855S, go to **http://www.cms.gov/MedicareProviderSupEnroll**.

BILLING NUMBER AND NATIONAL PROVIDER IDENTIFIER INFORMATION

The Medicare Identification Number, often referred to as a Medicare supplier number or Medicare billing number is a generic term for any number other than the National Provider Identifier (NPI) that is used by a DMEPOS supplier to bill the Medicare program.

The National Provider Identifier (NPI) is the standard unique health identifier for health care providers and suppliers and is assigned by the National Plan and Provider Enumeration System (NPPES). **To become a Medicare DMEPOS supplier, you must obtain an NPI and furnish it on this application prior to enrolling in Medicare or when submitting a change to your existing Medicare enrollment information.** Applying for the NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at **https://nppes.cms.hhs.gov**. For more information about NPI enumeration, visit **www.cms.gov/NationalProvIdentStand**.

NOTE: The Legal Business Name (LBN) and Tax Identification Number (TIN) that you furnish in Section 1B of this application must be the same LBN and TIN you used to obtain your NPI. Once this information is entered into PECOS from this application, your LBN, TIN and NPI ***must*** match exactly in both the Medicare Provider Enrollment Chain and Ownership System and the National Plan and Provider Enumeration System.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

All information on this form is required with the exception of those fields specifically marked as "optional." Any field marked as optional is not required to be completed nor does it need to be updated or reported as a "change of information" as required in 42 CFR § 424.516. However, it is highly recommended that if reported, these fields be kept up-to-date.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION *(Continued)*

- Type or print all information so that it is legible. Do not use pencil. Blue ink is preferred.
- When necessary to report additional information, copy and complete the applicable section as needed.
- Attach all supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your own records.

TIPS TO AVOID DELAYS IN YOUR ENROLLMENT

- Complete all required sections as shown in Section 1;
- Complete Section 9 for all delegated and authorized officials reported in Sections 14 and 15;
- Report at least one owner and one managing employee for each location;
- Enter your NPI in the applicable sections;
- Include the Electronic Funds Transfer (EFT) Agreement (CMS-588), when applicable, with your enrollment application;
- Respond timely to development/information requests; and
- Be sure the Legal Business Name shown in Section 1B matches the name on your tax documents.

Additional information and reasons for processing delays can be found at www.palmettogba.com/nsc.

PROCESS FOR OBTAINING MEDICARE APPROVAL

The standard process for becoming a Medicare DMEPOS supplier is as follows:

1. The supplier obtains the required National Provider Identification Number (NPI), surety bond and/or accreditation **PRIOR** to completing and submitting this application to the NSC MAC.
2. The supplier completes and submits this enrollment application (CMS-855S) and all supporting documentation to the NSC MAC.
3. The NSC MAC reviews the application and conducts a site visit to verify compliance with the supplier standards found at 42 CFR § 424.57, 424.58, and 42 CFR § 424.500–565.
4. After completing its review, the NSC MAC notifies the supplier in writing about its enrollment decision.

ADDITIONAL INFORMATION

The NSC MAC may request additional documentation to support or validate information reported on this application. You are responsible for providing this documentation within 30 days of the request.

The information you provide on this form is protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application to read the Privacy Act Statement.

ACRONYMS COMMONLY USED IN THIS APPLICATION

CFR: Code of Federal Regulations

DME MAC: Durable Medical Equipment Medicare Administrative Contractor

DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics and Supplies

EFT: Electronic Funds Transfer

IRS: Internal Revenue Service

LBN: Legal Business Name

LLC: Limited Liability Corporation

NPI: National Provider Identifier

NPPES: National Plan and Provider Enumeration System

NSC MAC: National Supplier Clearinghouse Medicare Administrative Contractor

PECOS: Provider Enrollment Chain and Ownership System

SSN: Social Security Number

TIN: Tax Identification Number

WHERE TO MAIL YOUR APPLICATION

The NSC MAC is responsible for processing your enrollment application. Mail this application to:

National Supplier Clearinghouse
Post Office Box 100142
Columbia, SC 29202-3142

Customer Service: 1-866-238-9652
Web: http://www.palmettogba.com/nsc

Overnight Mailing Address:
National Supplier Clearinghouse
Palmetto GBA* AG-495
2300 Springdale Drive, Bldg. 1
Camden, SC 29020

SECTION 1: BASIC INFORMATION

This section captures basic information and information about the reason you are submitting this application.

A. BUSINESS LOCATION

Provide the two-letter State Code (e.g., TX for Texas) where this business is physically located.

I	L

B. BUSINESS IDENTIFICATION

DMEPOS suppliers must furnish their National Provider Identifier (NPI), Tax Identification Number (TIN), and Supplier Billing Number (if issued) below.

NOTE: Each business location **MUST** have it's own NPI, unless enrolling as a sole proprietor/proprietorship with multiple locations. See Section 2C.

Legal Business Name (LBN)		
DeliverCareRx Pharmacy LLC		
National Provider Identifier (NPI)	Tax Identification Number (TIN)	Supplier Billing Number *(if issued)*
1205175510	36-4745271	

Read this in full prior to indicating the reason for submission in Section 1C.

NEW ENROLLEES AND THOSE REPORTING A NEW TAX ID NUMBER

You are considered a new enrollee if you are:

- Enrolling in the Medicare program as a DMEPOS supplier for the first time under the tax identification number reported in Section 1B.
- Currently enrolled in the Medicare program as a DMEPOS supplier but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new CMS-855S enrollment application in its entirety.
- A currently enrolled DMEPOS supplier under new ownership with a different tax identification number. **NOTE:** New owners of existing DMEPOS suppliers must submit a dated bill of sale with the effective date of the new ownership.

CURRENTLY ENROLLED MEDICARE DMEPOS SUPPLIERS

Adding a New Location

If you are currently enrolled as a Medicare DMEPOS supplier and are applying to enroll a new business location using a tax identification number that is already enrolled with the NSC MAC, you will need to complete only the required sections listed in Section 1C of this application for the new location.

Change of Information Other than Adding a New Location

If you are adding, removing, or changing information under your current Medicare supplier billing number, including a change of ownership that does not change the current tax identification number, you will need to complete the appropriate sections as instructed and submit any new documentation. Any change to your existing enrollment data must be reported within 30 days of the effective date of the change.

Reactivation

If your Medicare DMEPOS supplier billing number was deactivated, you will be required to submit an updated CMS-855S. You must also meet all current requirements for your supplier type to reactivate your supplier billing number.

Revalidation

If you have been contacted by the NSC MAC to revalidate your Medicare enrollment you will be required to submit an updated enrollment application. Do not submit an application for revalidation until you have been contacted by the NSC MAC.

Voluntary Termination

If you will no longer provide DMEPOS items or services to Medicare beneficiaries you should voluntarily terminate your enrollment in the Medicare program as a DMEPOS supplier.

NOTE: Enrollment applications submitted for "NEW ENROLLEES" **MUST** be signed by an Authorized Official, otherwise they will be returned unprocessed.

SECTION 1: BASIC INFORMATION *(Continued)*

C. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the Sections as indicated.

☒ You are a **new enrollee** in Medicare or are enrolling a new location with a tax identification number not previously enrolled with the NSC MAC.	**Complete all sections**
☐ You are **adding a new business location** using a tax identification number currently enrolled with the NSC MAC.	**Complete sections 1–7, 9 *(for managing employee only)*, 11 (optional), 12, and either 14 or 15**
☐ You are **adding a new business location** using a tax identification number **NOT** currently enrolled with the NSC MAC.	**Complete all sections**
☐ You are **reactivating** your Medicare Supplier Billing Number.	**Complete all sections**
☐ You are **revalidating** your Medicare enrollment.	**Complete all sections**
☐ You are **voluntarily terminating your Medicare enrollment.** Effective date of termination: ________________	**Complete sections 1, 2A, 4B, 4D, 11 (optional), and either 14 or 15**
☐ You are **changing your Medicare enrollment information** other than your tax identification number.	**Go to Section 1D**
☐ You are **changing your Tax Identification Number.**	**Complete all sections**

D. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

PLEASE NOTE: When reporting ANY information, Sections 1B, 7 and either 14 or 15 MUST always be completed in addition to completing the information that is changing within the required Section.

CHECK ALL THAT APPLY	REQUIRED SECTIONS
☐ Current Business Location Information	**1, 2, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Supplier Type *(submit licensure if applicable)* ☐ Products and Services *(submit accreditation if applicable)*	**1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Accreditation Information	**1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Address Information ☐ 1099 Mailing Address ☐ Correspondence Mailing Address ☐ Revalidation Mailing Address ☐ Remittance/Special Payment Mailing Address ☐ Record Storage Address	**1, 4 as applicable for the address that is being changed, 7, 11 (optional), 12 (if applicable), and either 14 or 15.**
☐ Comprehensive Liability Insurance Information	**1, 5, 7, 11 (optional), 12, and either 14 or 15**
☐ Surety Bond Information	**1, 6, 7, 11 (optional), 12, and either 14 or 15**
☐ Final Adverse Legal Actions	**1, 7, 11 (optional), 12, and either 14 or 15**
☐ Ownership and/or Managing Control Information (Organizations and/or Individuals)	**1, 7, 8 and/or 9, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Billing Agency Information	**1, 7, 10, 11 (optional), and either 14 or 15**
☐ Delegated Official	**1, 7, 9, 11 (optional), 12, 14 and 15**
☐ Authorized Official	**1, 7, 9, 11 (optional), 12 (if applicable), 15**
☐ Any other information not specified above	**1, 7, 11 (optional), 12 (if applicable), and either 14 or 15 and the applicable section or sub-section that is changing.**

SECTION 2: IDENTIFYING INFORMATION

A. BUSINESS LOCATION INFORMATION

- DMEPOS suppliers must complete and submit a separate CMS-855S enrollment application to enroll each physical location (i.e., store or other retail establishment) used to furnish Medicare covered DMEPOS to Medicare beneficiaries except for locations only used as warehouses or repair facilities.
- The address must be a specific street address as recorded by the United States Postal Service. Do not furnish a P.O. Box. If you are located in a hospital and/or other health care facility and you provide services to patients at that facility, furnish the name and address of the hospital or facility.
- A change to the business location address requires submission of professional and business licenses for the new address, and proof of insurance covering the new address.

If you are reporting a change of information to your current business location, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ______________

Business Location Name/Doing Business As Name
DeliverCareRx Pharmacy LLC

Business Location Address Line 1 *(Street Name and Number)*
8950 Gross Point Road

Business Location Address Line 2 *(Suite, Room, Apt. #, etc.)*
Suite 600

City/Town	State	ZIP Code + 4
Skokie	IL	60077

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(847) 965-1600	(847) 965-1611	jtollefson@delivercarerx.com

Date this Business Started at this Location *(mm/dd/yyyy)*	Date this Business Terminated at this Location *(if applicable) (mm/dd/yyyy)*
02/18/2013	

B. HOURS OF OPERATION

List your ***posted*** hours of operation as displayed at the business location in Section 2A above.

If you are reporting a change to your hours of operation, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ______________

You must list all hours of each day you are open to the public.

Check and/or complete all boxes and/or sections for each day as appropriate.
☐ Open 24/7 (Open 24 hours a day, 7 days a week)
☐ By Appointment Only

NOTE: "By Appointment Only" can only be checked if you meet the exemption requirements stated in 42 CFR § 424.57(c)(30).

Day of Week	Hours (Indicate A.M. or P.M)		Hours (Indicate A.M. or P.M)		Total Hours Open to the Public Each Day
	Open	Close	Open	Close	
Sunday					
Monday	8:00 am	5:00 pm			9
Tuesday	8:00 am	5:00 pm			9
Wednesday	8:00 am	5:00 pm			9
Thursday	8:00 am	5:00 pm			9
Friday	8:00 am	5:00 pm			9
Saturday					
				Total Hours Open to the Public Weekly	45

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

C. BUSINESS STRUCTURE INFORMATION

Identify the type of business structure for this supplier (Check one):

☐ Publicly Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
☐ Not Publicly Traded Corporation (regardless of whether supplier is "for-profit" or "non-profit")
☒ Limited Liability Company (LLC)
☐ Partnership ("general" or "limited")
☐ Sole Proprietor/Sole Proprietorship
☐ Government-Owned
☐ Other (Specify) ______________________

D. INTERNAL REVENUE SERVICE REGISTRATION INFORMATION

Identify how your business is registered with the IRS.

If you check Non-Profit submit a copy of your IRS Form 501(c)(3).

If you check Disregarded Entity submit a copy of your IRS Form 8832.

NOTE: If your business is a Federal and/or State government supplier indicate "Non-Profit" below.

☐ Proprietary ☐ Non-Profit ☒ Disregarded Entity

E. STATES WHERE ITEMS PROVIDED

Select all State(s)/Territory(ies) where you provide items or services to Medicare beneficiaries from the business location in Section 2A. For each State/Territory selected, submit all required licenses for the products and services being provided.

Jurisdiction A:
☐ All States in Jurisdiction A

☐ Connecticut
☐ Delaware
☐ District of Columbia
☐ Maine
☐ Maryland
☐ Massachusetts
☐ New Hampshire
☐ New Jersey
☐ New York
☐ Pennsylvania
☐ Rhode Island
☐ Vermont

Jurisdiction B:
☐ All States in Jurisdiction B

☒ Illinois
☐ Indiana
☐ Kentucky
☐ Michigan
☐ Minnesota
☐ Ohio
☐ Wisconsin

Jurisdiction C:
☐ All States and Territories in Jurisdiction C

☐ Alabama
☐ Arkansas
☐ Colorado
☐ Florida
☐ Georgia
☐ Louisiana
☐ Mississippi
☐ New Mexico
☐ North Carolina
☐ Oklahoma
☐ Puerto Rico
☐ South Carolina
☐ Tennessee
☐ Texas
☐ Virgin Islands
☐ Virginia
☐ West Virginia

Jurisdiction D:
☐ All States and Territories in Jurisdiction D

☐ Alaska
☐ Arizona
☐ California
☐ Guam
☐ Hawaii
☐ Idaho
☐ Iowa
☐ Kansas
☐ Missouri
☐ Montana
☐ Nebraska
☐ Nevada
☐ North Dakota
☐ Oregon
☐ South Dakota
☐ Utah
☐ Washington
☐ Wyoming
☐ Northern Mariana Islands
☐ American Samoa

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION

A. TYPE OF SUPPLIER

The supplier must meet all Medicare requirements for the DMEPOS supplier type checked. Any specialty personnel including, but not limited to, Respiratory Therapists and Orthotics/Prosthetics personnel must have current licensure as applicable to the supplier type checked as well as for all products and services checked in Sections 3C and 3D.

Check all that apply:

- ☐ Ambulatory Surgical Center
- ☐ Department Store
- ☐ Grocery Store
- ☐ Home Health Agency
- ☐ Hospital
- ☐ Indian Health Service or Tribal Facility
- ☐ Intermediate Care Nursing Facility
- ☐ Medical Supply Company
- ☐ Medical Supply Company with Orthotics Personnel
- ☐ Medical Supply Company with Pedorthic Personnel
- ☐ Medical Supply Company with Prosthetics Personnel
- ☐ Medical Supply Company with Prosthetic and Orthotic Personnel
- ☐ Medical Supply Company with Registered Pharmacist
- ☐ Medical Supply Company with Respiratory Therapist
- ☐ Nursing Facility (other)
- ☐ Ocularist
- ☐ Occupational Therapist
- ☐ Optician
- ☐ Orthotics Personnel
- ☐ Oxygen and/or Oxygen Related Equipment Supplier
- ☐ Pedorthic Personnel
- ☒ Pharmacy
- ☐ Physical Therapist
- ☐ Physician
- ☐ Physician/Dentist
- ☐ Physician/Optometrist
- ☐ Prosthetics Personnel
- ☐ Prosthetic and Orthotic Personnel
- ☐ Rehabilitation Agency
- ☐ Skilled Nursing Facility
- ☐ Sleep Laboratory/Medicine
- ☐ Sports Medicine
- ☐ Other______________________

B. ACCREDITATION INFORMATION

NOTE: If more than one accreditation needs to be reported, copy and complete this section for each.

Check one of the following and furnish any additional information as requested:

☐ The enrolling supplier business location in Section 2A is accredited.

☒ The enrolling supplier business location in Section 2A is exempt from accreditation requirements.

To determine if you qualify for exemption, go to **https://www.palmettogba.com/NSC**.

Name of Accrediting Organization	
Effective Date of Current Accreditation *(mm/dd/yyyy)*	Expiration Date of Current Accreditation *(mm/dd/yyyy)*

C. NON-ACCREDITED PRODUCTS

Check all that apply. These products do not require accreditation.

- ☐ Epoetin
- ☒ Immunosuppressive Drugs
- ☐ Infusion Drugs
- ☒ Nebulizer Drugs
- ☒ Oral Anticancer Drugs
- ☒ Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

NOTE: ☒ Check here if the supplier provides one or more of the products shown above but does not furnish any of the products and/or services listed in Section 3D. If checked, skip Section 3D and continue to Section 4.

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION *(Continued)*

D. PRODUCTS AND SERVICES FURNISHED BY THIS SUPPLIER

Check all that apply and submit all applicable licenses and/or certifications.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s) or services(s), check with your State. The NSC MAC website at **https://www.palmettogba.com/nsc** may offer guidance. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing privileges and/or overpayment collection.

- ☐ Automatic External Defibrillators (AEDs) and/or Supplies
- ☐ Blood Glucose Monitors and/or Supplies (mail order)
- ☐ Blood Glucose Monitors and/or Supplies (non-mail order)
- ☐ Breast Prostheses and/or Accessories
- ☐ Canes and/or Crutches
- ☐ Cochlear Implants
- ☐ Commodes/Urinals/Bedpans
- ☐ Continuous Passive Motion (CPM) Devices
- ☐ Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies
- ☐ Contracture Treatment Devices: Dynamic Splint
- ☐ Diabetic Shoes/Inserts
- ☐ Diabetic Shoes/Inserts—Custom
- ☐ Enteral Nutrients
- ☐ Enteral Equipment and/or Supplies
- ☐ External Infusion Pumps and/or Supplies
- ☐ Facial Prostheses
- ☐ Gastric Suction Pumps
- ☐ Heat & Cold Applications
- ☐ Hemodialysis Equipment and/or Supplies
- ☐ High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies
- ☐ Home Dialysis Equipment and/or Supplies
- ☐ Hospital Beds—Electric
- ☐ Hospital Beds—Manual
- ☐ Implanted Infusion Pumps and/or Supplies
- ☐ Infrared Heating Pad Systems and/or Supplies
- ☐ Insulin Infusion Pumps and/or Supplies
- ☐ Intermittent Positive Pressure Breathing (IPPB) Devices
- ☐ Intrapulmonary Percussive Ventilation Devices
- ☐ Invasive Mechanical Ventilation Devices
- ☐ Limb Prostheses
- ☐ Mechanical In-Exsufflation Devices
- ☐ Nebulizer Equipment and/or Supplies
- ☐ Negative Pressure Wound Therapy Pumps and/or Supplies
- ☐ Neuromuscular Electrical Stimulators (NMES) and/or Supplies
- ☐ Neurostimulators and/or Supplies
- ☐ Ocular Prostheses
- ☐ Orthoses: Custom Fabricated
- ☐ Orthoses: Prefabricated (non-custom fabricated)
- ☐ Orthoses: Off-the-Shelf
- ☐ Osteogenesis Stimulators
- ☐ Ostomy Supplies
- ☐ Oxygen Equipment and/or Supplies
- ☐ Parenteral Nutrients
- ☐ Parenteral Equipment and/or Supplies
- ☐ Patient Lifts
- ☐ Penile Pumps
- ☐ Pneumatic Compression Devices and/or Supplies
- ☐ Power Operated Vehicles (Scooters)
- ☐ Prosthetic Lenses: Conventional Contact Lenses
- ☐ Prosthetic Lenses: Conventional Eyeglasses
- ☐ Prosthetic Lenses: Prosthetic Cataract Lenses
- ☐ Respiratory Assist Devices
- ☐ Respiratory Suction Pumps
- ☐ Seat Lift Mechanisms
- ☐ Somatic Prostheses
- ☐ Speech Generating Devices
- ☐ Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads
- ☐ Surgical Dressings
- ☐ Tracheostomy Supplies
- ☐ Traction Equipment
- ☐ Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies
- ☐ Ultraviolet Light Devices and/or Supplies
- ☐ Urological Supplies
- ☐ Ventilators Accessories and/or Supplies
- ☐ Voice Prosthetics
- ☐ Walkers
- ☐ Wheelchair Seating/Cushions
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories
- ☐ Wheelchairs—Standard Manual
- ☐ Wheelchairs—Standard Manual Related Accessories
- ☐ Wheelchairs—Standard Power
- ☐ Wheelchairs—Standard Power Related Accessories

SECTION 4: IMPORTANT ADDRESS INFORMATION

A. 1099 MAILING ADDRESS

1. Organizational Suppliers (e.g., Corporations, Partnerships, LLCs, Sub-Chapter S)

If you are an organizational supplier, furnish the supplier's legal business name (as reported to the IRS) and TIN. Furnish 1099 mailing address information where indicated. A copy of the IRS Form CP-575 or other document issued by the IRS showing the TIN and LBN for this business MUST be submitted.

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ____________________

Organizational Suppliers: 1099 Mailing Address

Legal Business Name as Reported to the IRS		
DeliverCareRx Pharmacy LLC		
Tax Identification Number: 36-4745271	Prior Tax Identification Number *(if applicable)*:	
1099 Mailing Address Line 1 *(P.O. Box or Street Name and Number)*: 2100 Rexford Road		
1099 Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*: Suite 216		
1099 Mailing Address City/Town: Charlotte	1099 Mailing Address State: NC	1099 Mailing Address ZIP Code + 4: 28211-3484

2. Sole Proprietors

If you are a sole proprietor (the only owner of a business that is not incorporated), list your Social Security Number (SSN) and the full legal name associated with your SSN as reported to the IRS in the appropriate fields. If you want your Medicare payments reported under your Employer Identification Number (EIN) furnish it in the appropriate space below. Furnish 1099 mailing address information where indicated.

NOTE: Sole Proprietors: If you furnish an EIN, payment will be made to your EIN. If you do not furnish an EIN, payment will be made to your SSN. You can not use both an SSN and EIN. You can only use one number to bill Medicare. If furnishing an EIN, a copy of the IRS Form CP-575 or other document issued by the IRS showing the EIN and legal name for this business MUST be submitted.

If you are reporting a change to your 1099 mailing address, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ____________________

Sole Proprietors: 1099 Mailing Address

Social Security Number *(required)*	Employer Identification Number *(optional)*	Prior Employer Identification Number *(if applicable)*
Full Legal Name Associated with this Social Security Number		
1099 Mailing Address Line 1 *(P.O. Box or Street Name and Number)*		
1099 Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*		
1099 Mailing Address City/Town	1099 Mailing Address State	1099 Mailing Address ZIP Code + 4

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

B. CORRESPONDENCE MAILING ADDRESS

This is the address where correspondence will be sent to you by the NSC MAC and/or the DME MAC, **OR**

☒ Check here if you want all Correspondence mailed to your Business Location Address in Section 2A and skip this section.

If you are reporting a change to your Correspondence Mailing Address, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ______________

Business Location Name

Attention *(optional)*

Correspondence Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Correspondence Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

C. REVALIDATION REQUEST PACKAGE MAILING ADDRESS

This is the address where the NSC MAC will send your enrollment revalidation request package, **OR**

☒ Check here if your Revalidation Request Package should be mailed to your Business Location Address in Section 2A and skip this section, **OR**

☐ Check here if your Revalidation Request Package should be mailed to your Correspondence Mailing Address in Section 4B and skip this section.

If you are reporting a change to your Revalidation Request Package Mailing Address, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ______________

Business Location Name

Attention *(optional)*

Revalidation Request Package Mailing Address Line 1 *(P.O. Box or Street Name and Number)*

Revalidation Request Package Mailing Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number *(if applicable)*	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

SECTION 4: IMPORTANT ADDRESS INFORMATION *(Continued)*

D. REMITTANCE NOTICES/SPECIAL PAYMENTS MAILING ADDRESS

Medicare will issue all routine payments via electronic funds transfer (EFT). Since payment will be made by EFT, the special payments address below should indicate where all other payment information (e.g., remittance notices, non-routine special payments) should be sent, **OR**

☒ Check here if your Remittance Notices/Special Payments should be mailed to your Business Location Address in Section 2A and skip this section, **OR**

☐ Check here if your Remittance Notices/Special Payments should be mailed to your Correspondence Address in Section 4B and skip this section.

NOTE: If you are a new enrollee, you must submit an EFT Authorization Agreement (CMS-588) with this application.

If you need to make changes to your current EFT Authorization Agreement (CMS-588), contact your DME MAC.

If you are reporting a change to your Remittance Notice/Special Payment Mailing Address, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ____________

NOTE: Payments will be made in the supplier's legal business name as shown in Section 1B.

Special Payments Address Line 1 *(P.O. Box or Street Name and Number)*

Special Payments Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

E. MEDICARE BENEFICIARY MEDICAL RECORDS STORAGE ADDRESS

If the Medicare beneficiaries' medical records are stored at a location other than the Business Location Address in Section 2A in accordance with 42 CFR § 424.57 (c)(7)(E), complete this section with the name and address of the storage location. This includes the records for both current and former Medicare beneficiaries.

Post office boxes and drop boxes are not acceptable as a physical address where Medicare beneficiaries' records are maintained. The records must be the supplier's records, not the records of another supplier. If all records are stored at the Business Location Address reported in Section 2A, check the box below and skip this section.

☒ Records are stored at the Business Location Address reported in Section 2A.

If you are adding or removing a Storage Location, check the box below and furnish the effective date.

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ____________

1. Paper Storage

Name of Storage Facility

Storage Facility Address Line 1 *(Street Name and Number)*

Storage Facility Address Line 2 *(Suite, Room, Apt. #, etc.)*

City/Town	State	ZIP Code + 4

2. Electronic Storage

Do you store your patient medical records electronically? ■ **Yes** ☐ **No**

If yes, identify where/how these records are stored below. This can be a website, URL, in-house software program, online service, vendor, etc. This must be a site that can be accessed by the NSC MAC if necessary.

Site where electronic records stored

On pharmacy computer system, RxKey from vendor KeyCentrix

SECTION 5: COMPREHENSIVE LIABILITY INSURANCE INFORMATION

As required in 42 CFR § 424.57(c)(10), all DMEPOS suppliers must have comprehensive liability insurance in the amount of at least $300,000 per occurrence and the insurance must remain in force at all times. The NSC MAC, with full mailing address as shown on page 3, must be listed on the policy as a Certificate Holder. You must submit a copy of the liability insurance policy or evidence of self-insurance with this application. Failure to maintain the required insurance at all times will result in revocation of your Medicare supplier billing number retroactive to the date the insurance lapsed, and/or overpayment collection.

Malpractice Insurance is not the same as Comprehensive Liability Insurance and does not meet compliance for this requirement.

If you are changing your comprehensive liability insurance information, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ______________________

Name of Insurance Company			
Pharmacists Mutual Insurance Company			
Insurance Policy Number CPP 012769900	Date Policy Issued *(mm/dd/yyyy)* 01/21/2013		Expiration Date of Policy *(mm/dd/yyyy)* 01/21/2014
Insurance Agent's First Name Nick	Middle Initial	Last Name Garrett	Jr., Sr., M.D., etc.
Agent's Telephone Number (336) 317-7466	Agent's Fax Number *(if applicable)* (515) 295-4716		Agent's E-mail Address *(if applicable)* nick.garrett@phmic.com
Underwriter's Company Name Pharmacists Mutual Insurance Company			
Underwriter's Telephone Number (800) 247-5930	Underwriter's Fax Number *(if applicable)* (515) 295-4716		Underwriter's E-mail Address *(if applicable)* info@phmic.com

SECTION 6: SURETY BOND INFORMATION

As required in 42 CFR § 424.57(d), DMEPOS suppliers who are required to obtain a surety bond must complete this section. Furnish all requested information about the surety bond company and the surety bond. Submit a copy of the original surety bond, signed by a Delegated or Authorized Official, with this application.

☐ Check here if this supplier is not required to obtain a surety bond and skip to Section 7.

A. NAME AND ADDRESS OF SURETY BOND COMPANY

If you are changing your surety bond information, check the box below and furnish the effective date.

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ______________________

Legal Business Name of Surety Bond Company as Reported to the IRS		Tax Identification Number	
Western Surety Company		46-0204900	
Business Address Line 1 *(Street Name and Number)* P.O. Box 5077			
Business Address Line 2 *(Suite, Room, Apt. #, etc.)*			
City/Town Sioux Falls		State SD	ZIP Code + 4 57177-5077
Telephone Number (605) 336-0850	Fax Number *(if applicable)*	E-mail Address *(if applicable)*	

B. SURETY BOND INFORMATION

☐ **Change** **Effective Date** *(mm/dd/yyyy)*: ______________________

Amount of Surety Bond	Surety Bond Number
$ 50,000.00	61670762
Effective Date of Surety Bond *(mm/dd/yyyy)* 05/08/2013	If reporting a new bond, give cancellation date of the current bond *(mm/dd/yyyy)*

SECTION 7: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions such as convictions, exclusions, revocations and suspensions. All applicable final adverse legal actions must be reported regardless of whether any records were expunged or any appeals are pending.

A. CONVICTIONS

1. If this DMEPOS supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense it must be reported below. Reportable offenses include, but are not limited to:
   - Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions;
   - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions;
   - Any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and
   - Any felony that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR § 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

B. EXCLUSIONS, REVOCATIONS OR SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any past or current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

C. FINAL ADVERSE LEGAL ACTION HISTORY

If you are reporting a new final adverse legal action, check the box below and furnish the effective date.

☐ **New** **Effective Date** *(mm/dd/yyyy)*: ______________________

1. Has the supplier identified in Sections 1B/2A, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against it?

   ☐ YES–Continue Below ☒ NO–Skip to Section 8
2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/ administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 8: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

Only report organizations in this section. Individuals must be reported in Section 9. The supplier MUST have at least ONE owner or controlling entity and ONE managing employee reported in Section 8 and/or Section 9.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Sections 1B/2A, as well as any information on final adverse legal actions that have been imposed against that organization. For more information on "direct" and "indirect" owners and examples of organizations that must be reported in this section, go to: **https://www.cms.gov/MedicareProviderSupEnroll**. If there is more than one organization with ownership interest or managing control, copy and complete this section for each.

OWNERSHIP INTEREST (ORGANIZATIONS)

All organizations that have any of the following must be reported:

- 5 percent or more direct or indirect ownership of the DMEPOS supplier
- A partnership interest in the DMEPOS supplier, regardless of the partners' percentage of ownership
- Managing control of the DMEPOS supplier

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious Organizations
- Governmental and/or Tribal Organizations

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the DMEPOS supplier, or conducts the day-to-day operations of the DMEPOS supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the DMEPOS supplier in order to qualify as a managing organization. For example, it could be a management services organization under contract with the DMEPOS supplier to furnish management services for this business location.

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Facilities:

If a Federal, State, county, city or other level of government, the Indian Health Service (IHS), or an Indian tribe will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government, the IHS or Indian tribe must be reported as an owner or controlling entity. The DMEPOS supplier must submit a letter on the letterhead of the responsible government agency or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare. The appointed/elected official who signed the letter must be reported in Section 9.

Indian Health Service or Tribal Facilities:

Special rules concerning insurance and licenses apply. Contact the NSC MAC concerning these rules.

Non-Profit, Charitable and Religious Organizations:

Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a Board of Trustees or other governing body. The actual name of the Board of Trustees or other governing body must be reported in this section. While the organization must be reported in Section 8, individual board members must be reported in Section 9. Each non-profit organization must submit a copy of the IRS Form 501(c)(3) verifying its non-profit status.

SECTION 8: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) *(Continued)*

A. ORGANIZATION IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

☐ Check here if this section is not applicable for the supplier reported in Sections 1B/2A, and skip to Section 9.

If you are changing information about a currently reported owning or managing organization or adding or removing an owning or managing organization, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ____________

1. Complete all identifying information below.

Legal Business Name as Reported to the Internal Revenue Service
DeliverCareRx Inc

"Doing Business As" Name *(if applicable)*

Business Address Line 1 *(Street Name and Number)*
2100 Rexford Road

Business Address Line 2 *(Suite, Room, Apt. #, etc.)*
Suite 216

City/Town	State	ZIP Code + 4
Charlotte	NC	28211

Tax Identification Number *(Required)*	NPI *(if issued)*	Medicare Identification Number(s) *(if issued)*
46-1233821		

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(980) 224-9515	(980) 819-9849	

2. What is the above organization's ownership interest in the supplier reported in Section 1B/2A?
   ☒ 5% or Greater Direct/Indirect Owner ☐ Partner ☐ Government/Tribal Owner
3. What is the effective date the above organization acquired and/or ended the above ownership interest?
   ☒ **Acquired** **Effective Date** *(mm/dd/yyyy)*: 10/25/2012
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ____________
4. What is the above organization's managing control of the supplier reported in Section 1B/2A? (Check all that apply)
   ☒ Managing Organization ☐ Board of Trustees ☐ Governing Body ☐ Controlling Entity (Gov't/Tribe)
5. What is the effective date the above organization acquired and/or ended the above managing control?
   ☒ **Acquired** **Effective Date** *(mm/dd/yyyy)*: 10/25/2012
   ☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ____________

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for each organization reported in Section 8A.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ **New** **Effective Date** *(mm/dd/yyyy)*: ____________

1. Has the organization in Section 8A above, under any current or former name or business identity, ever had a final adverse legal action listed in Section 7 of this application imposed against it?
   ☐ YES–Continue Below ☒ NO–Skip to Section 9
2. If YES, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

Only report individuals in this section. Organizations must be reported in Section 8. The supplier MUST have at least ONE owner or controlling entity and ONE managing employee reported in Section 8 and/or Section 9.

NOTE: An individual owner may also be the managing employee to satisfy this requirement.

Complete this section with information about all individuals that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Sections 1B/2A, as well as any information on final adverse legal actions that have been imposed against that individual. For more information on "direct" and "indirect" owners and examples of individuals that must be reported in this section, go to: **https://www.cms.gov/MedicareProviderSupEnroll**. If there is more than one individual with ownership interest or managing control, copy and complete this section for each.

The following individuals must be reported in Section 9A:

- All persons who have a 5 percent or greater ownership (direct or indirect) interest in the DMEPOS supplier
- All officers, directors and board members if the DMEPOS supplier is a corporation (whether for-profit or non-profit)
- All managing employees of the DMEPOS supplier
- All individuals with a partnership interest, regardless of the partners' percentage of ownership; and
- All delegated and authorized officials reported in Sections 14 and 15

  Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 8 as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 9A1. Based on this example, the suppler would check the "5 Percent or Greater Direct/Indirect Owner" box in Section 9A2.

NOTE: All partners within a partnership must be reported in this application. This applies to both "General" and "Limited" partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the DMEPOS supplier, each limited partner must be reported in this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

For purposes of this application, the terms **"officer," "director,"** and **"managing employee"** are defined as follows:

- The term **"Officer"** is defined as any person whose position is listed as being that of an officer in the DMEPOS supplier's "articles of incorporation" or "corporate bylaws," OR anyone who is appointed by the board of directors as an officer in accordance with the DMEPOS supplier's corporate bylaws.
- The term **"Director"** is defined as a member of the DMEPOS supplier's "board of directors." It does not necessarily include a person who may have the word "Director" in his/her job title (e.g., Departmental Director, Director of Operations).
- The term **"Managing Employee"** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the DMEPOS supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the DMEPOS supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 8), the supplier is only required to report the appointed/elected official who signed the required letter legally and financially binding the Government/Tribal Organization and its managing employees in Section 9. Owners, partners, officers, and directors do not need to be reported.

SECTION 9: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) *(Continued)*

A. INDIVIDUAL IDENTIFICATION INFORMATION (OWNERSHIP AND/OR MANAGING CONTROL)

If you need to report more than one individual, copy and complete this section for each.

If you are changing information about a currently reported individual owner or manager or adding or removing an individual owner or manager, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ______________

1. Complete all identifying information below.

First Name	Middle Initial	Last Name	Jr., Sr.,M.D., etc.
Steve		Purdy	

Social Security Number *(Required)*	Date of Birth *(mm/dd/yyyy)*
152-74-5811	08/27/1969
Supplier Billing Number *(if issued)*	NPI *(if issued)*

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(980) 224-9515	(980) 819-9849	spurdy@delivercarerx.com

2. What is the above individual's title? President

3. What is the above individual's ownership interest in the supplier reported in Section 1B/2A?
☐ 5% or Greater Direct/Indirect Owner ☐ Partner

4. What is the effective date the above individual acquired and/or ended the above ownership interest?
Acquired **Effective Date** *(mm/dd/yyyy)*: ______________
☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ______________

5. What is the above individual's managing control of the supplier reported in Section 1B/2A? (Check all that apply).
☒ Officer ☐ Contracted Managing Employee ☐ Appointed/Elected Official
☒ Director ☒ W-2 Managing Employee

6. What is the effective date the above individual acquired and/or ended the above managing control?
× **Acquired** **Effective Date** *(mm/dd/yyyy)*: 10/25/2012
☐ **Ended** **Effective Date** *(mm/dd/yyyy)*: ______________

7. Is the above individual also a Delegated Official or Authorized Official reported in Sections 14 or 15?
☐ Delegated Official ☒ Authorized Official ☐ Neither

B. FINAL ADVERSE LEGAL ACTION HISTORY

Complete this section for the individual reported in Section 9A above.

If you are reporting a new final adverse legal action, check the box below and furnish effective date.

☐ **New** **Effective Date** *(mm/dd/yyyy)*: ______________

1. Has the individual reported in Section 9A, under any current or former name or business entity, ever had a final adverse legal action listed in Section 7 of this application imposed against him/her?
☐ YES–Continue Below ☒ NO–Skip to Section 10

2. If yes, report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the relevant final adverse legal action documents.

FINAL ADVERSE LEGAL ACTION	DATE	TAKEN BY	RESOLUTION

SECTION 10: BILLING AGENCY INFORMATION

A billing agency/agent is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency/agent you must complete this section. Even if you use a billing agency/agent, you remain responsible for the accuracy of the claims submitted on your behalf.

☐ Check here if this section does not apply and skip to Section 11.

If you are changing information about your current billing agency or adding or removing a billing agency, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ **Change** ☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ____________

BILLING AGENCY NAME AND ADDRESS

Legal Business Name as reported to the Internal Revenue Service **or** Individual Name as Reported to the Social Security Administration
ERX Network LLC

If Individual Billing Agent: Date of Birth *(mm/dd/yyyy)*

Billing Agency Tax Identification Number **or** Billing Agent Social Security Number *(required)*
75-2933687

Billing Agency "Doing Business As" Name *(if applicable)*
ERX Network

Billing Agency Address Line 1 *(Street Name and Number)*
300 Ridgefield CT

Billing Agency Address Line 2 *(Suite, Room, Apt. #, etc.)*
Ste 308

City/Town	State	ZIP Code + 4
Asheville	NC	28806-2315

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(800) 879-6153	(866) 543-7083	

Billing Agency/Agent Medicare Identification Number (PTAN) *(if issued)*	Billing Agency/Agent National Provider Identifier (NPI) *(if issued)*

SECTION 11: CONTACT PERSON INFORMATION

If questions arise while processing this application, the NSC MAC will contact the individual checked below.

☐ Contact any Delegated Official reported in Section 14
☐ Contact any Authorized Official reported in Section 15
☒ Contact the person reported below

First Name	Middle Initial	Last Name	Jr., Sr., M.D., etc.
John		Tollefson	

Contact Person Address Line 1 *(Street Name and Number)*
8950 Gross Point Road

Contact Person Address Line 2 *(Suite, Room, Apt. #, etc.)*
Suite 600

City/Town	State	ZIP Code + 4
Skokie	IL	60077

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*
(312) 953-6354	(866) 571-0413	jtollefson@delivercarerx.com

Relationship or Affiliation to this Supplier *(Spouse, Secretary, Attorney, Billing Agent, etc.)*
Manager

NOTE: The Contact Person reported in this section will only be authorized to discuss issues concerning this enrollment application. The NSC MAC will not discuss any other Medicare issues for this supplier with the above Contact Person.

SECTION 12: SUPPORTING DOCUMENTATION INFORMATION

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, adding a new location, reactivating or revalidating, you must provide all applicable documents. For changes, only submit documents that are applicable to the change requested. All enrolling DMEPOS suppliers are required to furnish information on all Federal, State, and local professional and business licenses, certifications, and/or registrations required to practice as a DMEPOS supplier in the State of the business location as reported in Section 1A. Check the NSC MAC website for further guidance on supplier requirements. You are responsible for furnishing and adhering to all required licensure and/or certification requirements, etc. for the supplies/services you provide.

The enrolling DMEPOS supplier may submit a notarized Certificate of Good Standing from the DMEPOS supplier's business location's State licensing/certification board or other medical association, in lieu of copies of the requested documents. This certificate cannot be more than 30 days old.

If the enrolling DMEPOS supplier has had a previously revoked or suspended license, certification, or registration reinstated, attach a copy of the reinstatement notice with this application.

MANDATORY FOR ALL NEW APPLICATIONS AND/OR ADDITIONAL LOCATIONS

☒ Copies of all Federal, State, and/or local (city/county) professional and business licenses, certifications and/or registrations for applicable specialty supplier types, products and services

☒ Copy of comprehensive liability insurance policy

NOTE: The NSC MAC must be listed as a certificate holder

☒ Written confirmation from the IRS confirming your Tax Identification Number and Legal Business Name provided in Section 1B (e.g., IRS Form CP-575)

NOTE: This information is needed if the applicant is enrolling a professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.

☒ Completed Form CMS-588, Electronic Funds Transfer Authorization Agreement. Include a voided check.

NOTE: If you currently receive payments electronically and are not making a change to your banking information, the CMS-588 is not required.

MANDATORY, IF APPLICABLE

☐ Copy of IRS Determination Letter, if supplier is registered with the IRS as non-profit (e.g., IRS Form 501(c)(3))

× Written confirmation from the IRS if your business is registered as a Limited Liability Company (LLC) confirming your LLC is automatically classified as a Disregarded Entity (e.g., IRS Form 8832)

NOTE: A Disregarded Entity is an eligible entity that is not treated as a separate entity from its single owner for income tax purposes.

☐ Copies of all final adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters)

☐ If Medicare payments due a supplier are being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), the supplier must provide a statement in writing **from the bank** (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.

☐ Copy of delegated official's W-2 if one has been designated

☐ Copy of your bill of sale if you purchased an existing DMEPOS supplier with an active Medicare supplier billing number

☒ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement, if you want to be a participating supplier

☒ Copy of Surety Bond

☐ Copy of attestation letter for government entities and tribal facilities

SECTION 13: PENALTIES FOR FALSIFYING INFORMATION ON THIS APPLICATION

This section explains the penalties for deliberately furnishing false information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.
2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, "knowingly and willfully," makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program. The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.
3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
   a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

   The Act imposes a civil penalty of $5,000 to $10,000 per violation, plus three times the amount of damages sustained by the Government
4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.
5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.
6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to executive a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment."

   Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 14: ASSIGNMENT OF DELEGATED OFFICIAL(S) *(Optional)*

A **DELEGATED OFFICIAL** means an individual who is delegated the authority to report changes and updates to the supplier's enrollment record by an authorized official. The delegated official must be an individual with "ownership or control interest in" (as that term is defined in Section 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the supplier. An independent contractor is not considered employed by the supplier and therefore cannot be a delegated official.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare enrollment information. Even when delegated officials are reported in this application, the authorized official retains the authority to make changes and/or updates.

You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the enrollment information.

The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, a delegated official certifies that he or she has read the Penalties for Falsifying Information in Section 13 and the Certification Statement in Section 15A and agrees to adhere to all of the stated requirements. The delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information, the delegated official certifies that the information provided is true, correct and complete.

The signature of an authorized official in Section 14 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 14. If you are delegating more than two individuals, copy and complete this section for each additional delegated individual.

NOTE: A delegated official who is being removed does not have to sign or date this application.

ASSIGNMENT OF DELEGATED OFFICIAL

All Delegated Officials must be reported in Section 9 of this application.

If you are adding or removing a delegated official, check the applicable box and furnish the effective date.

1st Delegated Official's Name and Signature

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ____________________

Under penalty of perjury, I, the undersigned, certify that I have read and understand the Certification Statement in Section 15A and accept the role of Delegated Official.

Delegated Official First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

Telephone Number	E-mail Address *(if applicable)*

Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

2nd Delegated Official's Name and Signature

☐ **Add** ☐ **Remove** **Effective Date** *(mm/dd/yyyy)*: ____________________

Under penalty of perjury, I, the undersigned, certify that I have read and understand the Certification Statement in Section 15A and accept the role of Delegated Official.

Delegated Official First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

Telephone Number	E-mail Address *(if applicable)*

Authorized Official's Signature Assigning this Delegation *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 15: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT AND SIGNATURE

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or 5% or greater direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's enrollment information in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

By his/her signature, an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or have its billing privileges revoked from the Medicare program if any requirements are not met. All signatures must be original and in blue ink. Faxed, photocopied, or stamped signatures will not be accepted.

By signing this application, an authorized official agrees to immediately notify the NSC MAC if any information in this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the NSC MAC of any future changes to the information contained in this application after the supplier is enrolled in Medicare, within 30 days of the effective date of the change.

Applications submitted for initial enrollment must be signed by an Authorized Official or they will be rejected and returned unprocessed.

The certification below includes additional requirements that the supplier must meet and maintain to bill the Medicare program. Read these requirements carefully. By signing, you are attesting to having read the requirements and understanding them.

Your signature further stipulates that you agree to adhere to all of the requirements listed below and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

A. CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** Section 15B of this certification statement to become enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NSC MAC of this fact immediately.
2. I agree to notify the NSC MAC of any current or future changes to the information contained in this application in accordance with the timeframes established in 42 CFR § 424.57. I understand that any change in the business structure of this supplier may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare identification number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Social Security Act and all applicable Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
5. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, delegated official or authorized official thereof is currently sanctioned, suspended, debarred, or excluded by Medicare or any State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
6. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
7. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
8. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of Medicare a copy of my most recent accreditation survey, together with any information related to the survey that Medicare may require (including corrective action plans).

SECTION 15: AUTHORIZED OFFICIAL CERTIFICATION STATEMENT AND SIGNATURE *(Continued)*

B. AUTHORIZED OFFICIAL SIGNATURE(S)

All Authorized Officials must be reported in Section 9 of this application.
If you are adding or removing an Authorized Official, check the applicable box and furnish the effective date.

1st Authorized Official
I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

1st Authorized Official's Information and Signature

☒ **Add** ☐ **Remove** **Effective Date** ***(mm/dd/yyyy)*:** 04/17/2013

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Steve		Purdy	

Telephone Number	E-mail Address *(if applicable)*	Title/Position
(980) 224-9515	spurdy@delivercarerx.com	President

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	**Date Signed *(mm/dd/yyyy)***

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

2nd Authorized Official
I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

2nd Authorized Official's Information and Signature

☐ **Add** ☐ **Remove** **Effective Date** ***(mm/dd/yyyy)*:** ____________

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Telephone Number	E-mail Address *(if applicable)*	Title/Position

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	**Date Signed *(mm/dd/yyyy)***

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

3rd Authorized Official
I have read the contents of this application and the certification statement in Section 15A of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the NSC MAC to verify this information.

3rd Authorized Official's Information and Signature

☐ **Add** ☐ **Remove** **Effective Date** ***(mm/dd/yyyy)*:** ____________

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Telephone Number	E-mail Address *(if applicable)*	Title/Position

Authorized Official Signature *(First, Middle, Last Name, Jr., Sr., M.D., etc.)*	**Date Signed *(mm/dd/yyyy)***

All signatures must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed or copied signatures will not be accepted.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Authority for maintenance of the system is given under provisions of sections 1102(a) (Title 42 U.S.C. 1302(a)), 1128 (42 U.S.C. 1320a–7), 1814(a)) (42 U.S.C. 1395f(a)(1), 1815(a) (42 U.S.C. 1395g(a)), 1833(e) (42 U.S.C. 1395l(3)), 1871 (42 U.S.C. 1395hh), and 1886(d)(5)(F), (42 U.S.C. 1395ww(d)(5)(F) of the Social Security Act; 1842(r) (42 U.S.C. 1395u(r)); section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1), and 1124A (42 U.S.C. 1320a–3a), section 4313, as amended, of the BBA of 1997; and section 31001(i) (31 U.S.C. 7701) of the DCIA (Pub. L. 104–134), as amended.

The information collected here will be entered into the Provider Enrollment, Chain and Ownership System (PECOS).

PECOS will collect information provided by an applicant related to identity, qualifications, practice locations, ownership, billing agency information, reassignment of benefits, electronic funds transfer, the NPI and related organizations. PECOS will also maintain information on business owners, chain home offices and provider/chain associations, managing/ directing employees, partners, authorized and delegated officials, supervising physicians of the supplier, ambulance vehicle information, and/or interpreting physicians and related technicians. This system of records will contain the names, social security numbers (SSN), date of birth (DOB), and employer identification numbers (EIN) and NPI's for each disclosing entity, owners with 5 percent or more ownership or control interest, as well as managing/directing employees. Managing/directing employees include general manager, business managers, administrators, directors, and other individuals who exercise operational or managerial control over the provider/ supplier. The system will also contain Medicare identification numbers (i.e., CCN, PTAN and the NPI), demographic data, professional data, past and present history as well as information regarding any adverse legal actions such as exclusions, sanctions, and felonious behavior.

The Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a "routine use." The CMS will only release PECOS information that can be associated with an individual as provided for under Section III "Proposed Routine Use Disclosures of Data in the System." Both identifiable and non-identifiable data may be disclosed under a routine use. CMS will only collect the minimum personal data necessary to achieve the purpose of PECOS. Below is an abbreviated summary of the six routine uses. To view the routine uses in their entirety go to: **http://www.cms.gov/RegulationsandGuidance/Guidance/PrivacyActSystemofRecords/downloads/0532.pdf**.

1. To support CMS contractors, consultants, or grantees, who have been engaged by CMS to assist in the performance of a service related to this collection and who need to have access to the records in order to perform the activity.
2. To assist another Federal or state agency, agency of a state government or its fiscal agent to:
   a. Contribute to the accuracy of CMS's proper payment of Medicare benefits,
   b. Enable such agency to administer a Federal health benefits program that implements a health benefits program funded in whole or in part with federal funds, and/or
   c. Evaluate and monitor the quality of home health care and contribute to the accuracy of health insurance operations.
3. To assist an individual or organization for research, evaluation or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for payment related projects.
4. To support the Department of Justice (DOJ), court or adjudicatory body when:
   a. The agency or any component thereof, or
   b. Any employee of the agency in his or her official capacity, or
   c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or
   d. The United States Government, is a party to litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which CMS collected the records.
5. To assist a CMS contractor that assists in the administration of a CMS administered health benefits program, or to combat fraud, waste, or abuse in such program.
6. To assist another Federal agency to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds.

The applicant should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1056. The time required to complete this information collection is estimated to be 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

EXHIBIT B

PO BOX 100142 | COLUMBIA, SC 29202-3142 | PALMETTOGBA.COM | ISO 9001
NATIONAL SUPPLIER CLEARINGHOUSE MEDICARE ADMINISTRATIVE CONTRACTOR

PALMETTO GBA®
A CELERIAN GROUP COMPANY

September 17, 2013

DELIVERCARERX PHARMACY LLC
8950 GROSS POINT ROAD
SUITE 600
SKOKIE IL 60077

633993 000004
0001 of 0002

NPI: 1205175510
PTAN: 6824550001

Dear DELIVERCARERX PHARMACY LLC:

Thank you for applying to the National Supplier Clearinghouse (NSC) as a supplier of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS). Your application for billing privileges has been approved effective September 16, 2013 for the location listed below and your participation status is Participating. Please note each location where a DMEPOS supplier provides Medicare-covered items to beneficiaries must obtain billing privileges.

Federal law (OBRA 1989) requires suppliers to file a claim for all beneficiaries to whom Medicare Part B services have been provided. You will use the National Provider Identifier (NPI) listed on the CMS 855S form to bill the Durable Medical Equipment Medicare Administrative Contractor (DME MACs). The DME MACs have been notified of your approval and information regarding the billing process may be found on their respective Web sites where you may also subscribe to receive timely listserv messages regarding Medicare billing policies.

Jurisdiction A- NHIC, Corp., www.medicarenhic.com/dme
Jurisdiction B- National Government Services, www.ngsmedicare.com
Jurisdiction C- CGS, www.cgsmedicare.com
Jurisdiction D- Noridian Administrative Services, www.noridianmedicare.com/dme

To establish electronic claim submission, contact the Common Electronic Data Interchange (CEDI) at www.ngscedi.com or 866-311-9184.

You have also been issued 6824550001, which is your Provider Transaction Access Number (PTAN), previously referred to as the NSC supplier number. The PTAN is an identifier to be used when contacting the NSC or the DME MAC(s) with general inquiries. Please note some of the DME MACs may refer to the PTAN as the supplier or legacy number. Suppliers are reminded to register their NSC PTANs with National Plan & Provider Enumeration System (NPPES) once assigned to maintain updated information with all carriers.

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0002 of 0002

All suppliers are required to maintain compliance with the Medicare DMEPOS supplier standards. To promote a higher level of ethical and lawful conduct within the DMEPOS program, the Office of Inspector General has developed a Program Compliance Guidance (www.oig.hhs.gov/authorities/docs/frdme.pdf).

Also, all suppliers are required to notify the NSC of any changes to the information provided on the CMS 855S form within 30 days (supplier standard #2). Inaccurate supplier information may impact claims processing.

If you have questions regarding the DMEPOS enrollment process, please contact the NSC at (866) 238-9652. To receive the most updated information directly to your email, register to receive NSC ListServ messages and news articles by visiting www.PalmettoGBA.com/NSC.

Sincerely,

Nancy C Parker, Director

DELIVERCARERX PHARMACY LLC
8950 GROSS POINT ROAD
SUITE 600
SKOKIE, IL 60077

EXHIBIT C

Case: 1:14-cv-07976 Document #: 57-3 Filed: 06/22/15 Page 1 of 3 PageID #:503

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0373

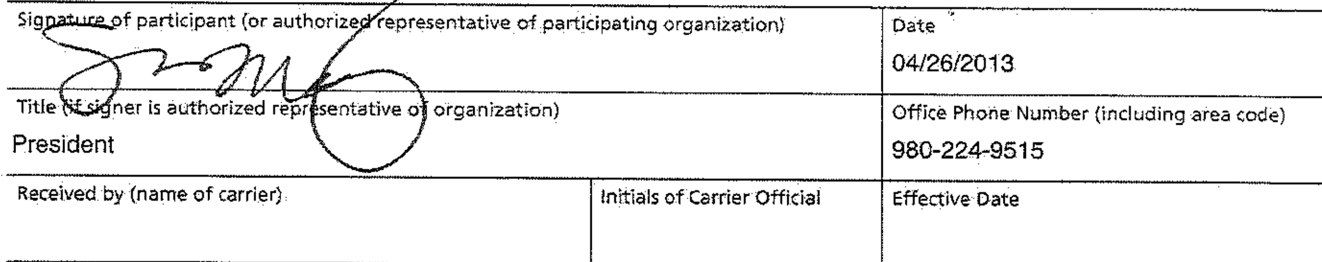
MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*
DeliverCareRx Pharmacy LLC 8950 Gross Point Road, Ste 600 Skokie, IL 60077	1205177510

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC)/carrier with whom this agreement is being filed.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date:** If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective ________________.
3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
   a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
   b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.



Signature of participant (or authorized representative of participating organization)		Date 04/26/2013
Title (if signer is authorized representative of organization) President		Office Phone Number (including area code) 980-224-9515
Received by (name of carrier)	Initials of Carrier Official	Effective Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

INSTRUCTIONS FOR THE MEDICARE PARTICIPATING PHYSICIAN AND SUPPLIER AGREEMENT (CMS-460)

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have Medigap coverage not connected with their employment and who assign both their Medicare and Medigap payments to participants. After we have made payment, Medicare will send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

Currently, the large majority of physicians, practitioners and suppliers are billing under Medicare participation agreements.

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all MAC/carriers have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their MAC/carrier to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.
- New physicians, practitioners, and suppliers can sign the participation agreement and become a Medicare participant at the time of their enrollment into the Medicare Program. The participation agreement will become effective on the date of filing; i.e., the date the participant mails (post-mark date) the agreement to the carrier or delivers it to the carrier.

Contact your MAC/carrier to get the exact dates the participation agreement will be accepted, and to learn where to send the agreement.

WHAT TO DO DURING OPEN ENROLLMENT:

If you choose to be a participant:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement (CMS-460) and mail it (or a copy) to each carrier to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each carrier to which you submit claims, advising of your termination effective the first day of the next calendar year. This written notice must be postmarked prior to the end of the current calendar year.

WHAT TO DO IF YOU'RE A NEW PHYSICIAN, PRACTITIONER OR SUPPLIER:

If you choose to be a participant:

- Complete the blank agreement (CMS-460) and submit it with your Medicare enrollment application to your MAC/carrier.
- If you have already enrolled in the Medicare program, you have 90 days from when you are enrolled to decide if you want to participate. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send to your MAC/carrier.

If you decide not to participate:

- Do nothing. All new physicians, practitioners, and suppliers that are newly enrolled are automatically non-participating. You are not considered to be participating unless you submit the CMS-460 form to your MAC/carrier.

We hope you will decide to be a Medicare participant.

Please call the MAC/carrier in your jurisdiction if you have any questions or need further information on participation.

DO NOT SEND YOUR CMS-460 FORM TO CMS, SEND TO YOUR MAC/CARRIER. IF YOU SEND YOUR FORMS TO CMS, IT WILL DELAY PROCESSING OF YOUR CMS-460 FORMS.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various Medicare Administrative Contractor (MAC)/carrier contacts including the MAC/carrier medical directors, please visit the CMS web site at *http://www.cms.gov/*.